Table. Multivariate Analysis of Baseline Predictors of Overall Survival in Patients Receiving Sipuleucel-T

Multivariate Analysis		
Covariate	**Hazard ratio (95% CI)**	**p-value**
Age, y (>median vs ≤median)	1.437 (1.149-1.797)	0.001
Prior chemotherapy (yes vs no)	1.510 (1.155-1.973)	0.003
Alkaline phosphatase, U/L (>median vs ≤median)	1.680 (1.336-2.111)	<0.001
Race (Caucasians vs African Americans)	1.564 (1.200-2.037)	<0.001
Hemoglobin, g/dL (>median vs ≤median)	0.621 (0.491-0.785)	<0.001
PSA, ng/mL (>median vs ≤median)	1.719 (1.354-2.182)	<0.001

CI = confidence interval; PSA = prostate-specific antigen.

Source of Funding: This study was sponsored by Dendreon Pharmaceuticals, Inc

Infertility: Epidemiology & Evaluation II

Moderated Poster 35

Saturday, May 13, 2017 **1:00 PM-3:00 PM**

MP35-01

ATTITUDES TOWARDS FERTILITY AND REPRODUCTIVE HEALTH AMONG TRANSGENDER ADOLESCENTS

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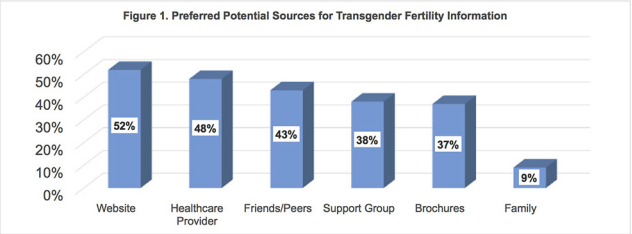
INTRODUCTION AND OBJECTIVES: Transgender/gender non-conforming adolescents (TGNC-A) often pursue hormonal therapies (puberty blockers; cross-sex hormones) to alleviate gender dysphoria. These therapies may cause impairments in gonadal histology that lead to infertility, such that fertility preservation in adolescence may be pursued. Despite this, little is known about the reproductive desires of TGNC-A. We aimed to address this gap by assessing attitudes towards fertility among TGNC-A.

METHODS: An online survey about sexual health in lesbian, gay, bisexual, transgender and queer (LGBTQ) adolescents ages 14-17 was conducted via Facebook from 9/16-10/16. We analyzed responses related to fertility and reproductive health among self-identified TGNC-A.

RESULTS: 172 TGNC-A (median age 16 years; 35% transgender men [female-to-male], 5% transgender women [male-to-female], 49% genderqueer/gender non-conforming; 52% white, 27% Hispanic, 23% multiracial, 7% African-American, 6% Asian) responded. Overall, 38% were interested in biological parenthood and 71% in adoption. Discussions about hormonal therapies with healthcare providers were relatively uncommon (11% discussed puberty blockers; 21% cross-sex hormones). Accordingly, only 20% have discussed fertility with a provider, and 18% have specifically discussed effects of hormones on fertility. However, 59% of TGNC-A surveyed were interested in learning more about fertility and family building options. Figure 1 illustrates preferred sources for this information; websites and healthcare providers were most common. Key themes/issues derived from qualitative comments included: stigma of LGBTQ parenthood, concerns about body dysphoria, cost of assisted reproductive technologies, and technical questions related to biological parenthood. Only 17% of respondents indicated they were uncomfortable answering questions about fertility.

CONCLUSIONS: TGNC-A expressed interest in multiple family building options, including adoption and biological parenthood. Both survey responses and qualitative comments identified the need for more education about these options. Fertility medicine specialists should be aware of the unique needs facing this emerging and increasingly visible population.



Source of Funding: none

MP35-02

VARIABLE ADOPTION OF WORLD HEALTH ORGANIZATION 2010 SEMEN ANALYSIS REFERENCE RANGES: THE DIFFERENCE BETWEEN "NORMAL" AND "ABNORMAL" MAY DEPEND ON WHERE YOU GO

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INTRODUCTION AND OBJECTIVES: There is no universal agreement on normal reference ranges for semen analysis (SA). Many laboratories use the World Health Organization (WHO) reference ranges, however the newest 2010 edition (WHO 5) is not without controversy. It is unknown how many laboratories utilize WHO 5 values now six years after their release. Our objective was to determine rates of adoption of WHO 5 criteria among US andrology labs. Variable reference range adoption leads to different categorization of results as "normal" or "abnormal" depending on where men obtain their SA.

METHODS: Clinical Laboratory Improvement Amendments (CLIA) laboratories certified to perform SA were extracted from CLIA (http://www.cdc.gov/clia/Resources/Laboratoriesearch.aspx) using a keyword search with: "andrology," "infertility," and "semen analysis." De-identified SA reports and reference ranges used were obtained by phone or email. Rates of adoption were computed by comparing reported values to WHO criteria. A chi-square test was used to compare the rate of WHO 5 criteria adoption between academic and non-academic centers.

RESULTS: We contacted 280 laboratories in 46 states. A total of 132 laboratories responded, with 104 (79%) laboratories performing SA in 32 states. Among labs performing SA, WHO 5 criteria was utilized by 63 (61%), while 29 (28%) used WHO 4 criteria. 12 (12%) laboratories used modified WHO criteria. WHO 5 criteria adoption was higher among academic centers (n=14, 86%) compared to non-academic centers (n=90, 57%) (P=0.04). Adoption rates varied by geographic region, ranging from 94% (16/17) in the Midwest to just 42% (11/26) in the West.

CONCLUSIONS: While the majority of laboratories have adopted WHO 5 criteria, a large percentage (39%) still use other criteria six years after the WHO 5 criteria were released. This variability could result in a male patient being characterized as "fertile" in one center and "subfertile" in another. The lack of consensus amongst laboratories in SA reference ranges could thus substantially impact management of the patient and his partner depending on where they seek treatment.